New Hampshire Insurance Department

REQUEST FOR INDEPENDENT EXTERNAL APPEAL OF A HEALTH CARE DECISION

ENROLLEE INFORMATION

Enrollee's Name: _____Patient's Name: _____

Mailing Address: _____

_____

Phone Number: Daytime (_____)_____ Evening (_____)_____

Enrollee's Insurance ID #: _____ Insurance Claim/Reference #: _____

INFORMATION ABOUT YOUR EMPLOYER

Employer's Name: _____

Employer's Phone Number: _____

Is the insurance you have through your employer a self-funded plan? _____If you are not certain please check with your employer. These types of plans are not eligible for external review.

INFORMATION ABOUT YOUR MANAGED CARE INSURANCE COVERAGE

Health Insurance Company's Name: _____

Insurer Mailing Address: _____

_____

Insurer Telephone Number: (_____)_____

Person at Health Insurance Company Involved with Your Appeal: _____

INFORMATION ABOUT YOUR TREATING HEALTH CARE PROVIDER

Name of Health Care Provider: _____

Type of Provider: Medical Doctor Other (please specify): _____

Provider Mailing Address: _____

_____

Provider Phone Number: (_____)_____

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your personal representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

_____ _____

Signature of Enrollee (or legal representative)* Date

*(Parent, Guardian, Conservator, or Other – Please Specify)

Address of Authorized Representative: _____

_____

Phone Number: Daytime (_____)_____ Evening (_____)_____

REQUEST FOR A TELEPHONE CONFERENCE

(Fill out this section only if you would like to request a telephone conference.)

If you, your representative or your treating health care provider would like to discuss your case with the independent review organization and your insurer in a telephone conference, check the box below and explain why you think it is important to be allowed to speak about your case. If you do not request a telephone conference, the reviewer will base its decision on the written information only. Your request for a telephone conference will be granted only if there is a good reason why the written information would not be sufficient.

☐ Yes, I want a phone conference. My reason for requesting a phone conference is that _____

_____

_____.

HEALTH CARE DECISION IN DISPUTE

Describe your health insurer's decision in your own words. Include any information you have about the heath care services, supplies or drugs being denied, including dates and names of health care providers. Explain why you disagree with the insurer. Attach additional pages if necessary. Also attach pertinent medical records and (if possible) a statement from your treating health care provider indicating why the disputed service, supply, or drug is medically necessary.

_____

_____

_____

_____

_____

_____

_____

_____

EXPEDITED REVIEW

You may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Is this a request for an expedited appeal? Yes_____ No_____

REQUEST FOR EXTERNAL REVIEW AND RELEASE OF MEDICAL RECORDS

I, _____, hereby request an external appeal and authorize my insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the New Hampshire Insurance Department. I understand that the independent review organization and the Insurance Department will use this information to make a determination on my appeal and that the information will be kept confidential and not be released to anyone else. I understand that neither the Commissioner nor the external appeal entity may authorize services in excess of those covered by my health care plan. This release is valid for one year.

_____ _____

Signature of Enrollee (or legal representative)* Date

*(Parent, Guardian, Conservator, or Other – Please Specify)

WHAT TO SEND AND WHERE TO SEND IT

- ☐ This completed application form signed and dated (see section above).
- ☐ A copy of the letter from your health insurer denying your request at the second and final level of their internal appeals process.
- ☐ A photocopy of your insurance card or other evidence that you are insured by the health insurance company named in this application.
- ☐ A copy of your certificate of coverage or your insurance policy benefit booklet, which lists your benefits.
- ☐ Any medical records, statements from your treating health care providers or other information that you would like the independent review organization to consider in reviewing your case.

Call the Insurance Department at 800-852-3416 or 271-2261 if you need help with this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for independent external review.

If you are requesting a standard review, send all paperwork to:

Independent External Review
New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301

If you are requesting an expedited review, call the Insurance Department before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

New Hampshire Insurance Department

CERTIFICATION OF TREATING HEALTH CARE PROVIDER FOR EXPEDITED CONSIDERATION OF A PATIENT'S EXTERNAL APPEAL

NOTE TO THE TREATING HEALTH CARE PROVIDER:

Patients can request an independent external appeal when a managed care insurer has denied a health care service, supply or drug on the basis of a utilization review determination that the requested service, supply or drug does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. The New Hampshire Insurance Department oversees external appeals. The standard process for handling external review can take up to 52 days. Expedited review is available only if the patient's treating health care provider certifies that adherence to the time frame for standard review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. Expedited review must be completed in at most 72 hours. This form is for the purpose of providing the certification necessary to trigger expedited review.

GENERAL INFORMATION:

Name of Treating Health Care Provider: _____

Mailing Address: _____

_____

Phone Number: (_____)_____ Fax Number: (_____)_____

Licensure and Area of Clinical Specialty: _____

_____

Name of Patient: _____

Patient's Health Insurer Member ID #: _____

CERTIFICATION:

I hereby certify that: I am a treating health care provider for _____ (hereafter referred to as "the patient"); that adherence to the time frame for conducting a standard review of the patient's external appeal would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that, for this reason, the patient's appeal of the denial by the patient's health insurer of requested medical services should be processed on an expedited basis.

_____

Treating Health Care Provider's Name (Please Print)

_____ _____

Signature Date